IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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March 31, 2010

Rene Stephens
Campus View Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

RE: Campus View Home, provider #13G070

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey of Campus View Home, which was conducted on March 25, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 13, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by April 13, 2010. If a request for informal dispute resolution is received after April 13, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Trish O'Hara, RN Common abbreviations/symbols used in this report are: IDT - Interdisciplinary Team IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED MAY 07 2010 FACILITY STANDARDS	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of investigations, the facility's policy and procedures, and staff interview, it was determined the facility failed to ensure all allegations of abuse were immediately reported to the administrator for 1 of 1 individuals (Individual #2), for whom abuse was alleged. This resulted in the potential for on-going abuse to occur. Findings include: 1. The facility's Policy Against Abuse and Neglect, modified 3/17/05, stated physical abuse "refers to any physical motion or action, (e.g., hitting, slapping, punching, kicking, pinching, etc.) by	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rene Stephens	Administrator	4/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 which bodily harm or trauma occurs." The policy stated "Any injuries of unknown origin and any allegations of mistreatment must be reported to the Administrator, regardless of who is [sic] the perpetrator..." The facility's investigations, from 5/1/09 - 3/22/10, were requested for review. The facility had completed one investigation, undated, which stated Individual #2 alleged a staff member physically abused him on 3/11/10. The investigation stated Individual #2 told three separate staff, on 3/11/10, that a forth staff had kicked him in the leg. However, the investigation did not document administrator notification until 3/15/10. When asked during an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the QMRP stated staff had not reported the incident until 3/15/10. The facility failed to ensure allegations of abuse were immediately reported to the administrator.	W 153	W153: Staff retraining at all facilities will be completed to ensure that any injuries of unknown origin, allegations of mistreatment are reported immediately, to the administrator as per the policy and procedure manual. Policy has been modified to include the following: "Failure to report any of these events in a timely manner may result in disciplinary action for those responsible to report." A review of files and practices by QMRPs, Facility Managers, and Quality Assurance Manager will ensure that allegations are reported within the specified time frame and follow up training or disciplinary action will be taken. Training will be done initially upon hire and annually all staff will receive mandatory training regarding reporting incidents immediately. Responsible: QMRP, Facility Manager, Quality Assurance Manager Date of correction: April 21th, 2010	
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of investigations and staff interview, it was determined the facility failed to ensure appropriate corrective action was taken for 1 of 1 individuals (Individual #2) for whom an investigation was completed. This resulted in a lack of training with regards to immediate reporting of potential abuse, neglect, and mistreatment. The findings include:	W 157	Pen + Ink Addendum - review of files and practices takes place each business day per the Administrator. - M. Case 5/10/10	

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W 157	Continued From page 2 1. Individual #2's 2/20/10 IPP stated he was a 38 year old male whose diagnoses included mild mental retardation and schizophrenia. An investigation, undated, stated Individual #2 alleged a staff member physically abused him on 3/11/10. The investigation stated Individual #2 told three separate staff, on 3/11/10, that a forth staff had kicked him in the leg. However, the staff did not report the incident to administration until 3/15/10. The investigation did not address the staffs' failure to report the incident or include corrective action such as retraining of staff regarding abuse reporting. When asked during an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the QMRP stated staff should have reported the incident immediately. The QMRP stated no corrective action or retraining of staff had taken place. The facility failed to ensure appropriate corrective action was taken for all concerns identified in Individual #2's abuse investigation.	W 157	W157: Staff retraining at all facilities has been completed to ensure that any injuries of unknown origin or allegations of mistreatment are reported immediately, to the administrator as per the policy and procedure manual. Training will be done initially upon hire and annually all staff will receive mandatory training regarding reporting incidents immediately upon discovery of an allegation. A review of files and practices will ensure that allegations are reported within the specified time frame and follow up training or disciplinary action will be taken. Responsible: Quality Assurance Manager, QMRP, Administrator Date of correction: April 21th, 2010 Pen + Ink Addendum - review of files and practices takes place each business day per the Administrator. - LPN. Case 5/10/10	
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the training programs included the frequency that data was to be collected for 3 of 3 individuals, (Individuals #1 -	W 237		

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W 237	Continued From page 3 #3) whose training programs were reviewed. Using inconsistent frequencies had the potential to prevent the facility from making objective decisions regarding individuals success or lack of success. The findings include: 1. Individual #3's 6/1/09 IPP stated he was a 29 year old male whose diagnoses included moderate mental retardation and Down Syndrome. Individual #3's IPP included the following formal training objectives which did not specify the frequency at which data was to be collected: - Stay on topic during a group discussion. - Wait his turn to speak during conversation. - Chew his food before swallowing. - Swallow food pieces before placing another bite in his mouth. - Wash his hands after using the restroom. - Shower regularly. - Wear clothing appropriate for the weather. - Maintain a consistent dietary intake of calories. - Repeat the name of his oral medication. - Work on a project with his peers. - Record scheduled events on his daily planner. - Discuss a current event. - Help clear dishes from the table after a meal. - Wipe the table after a meal. In an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the QMRP stated that frequencies for data collection were not included in the programs for Individual #3. 2. Individual #1's 11/21/09 IPP stated he was a 47 year old male whose diagnoses included severe mental retardation and cerebral palsy.	W 237	W237: Programs will be adjusted to include Frequency of Data to be collected and this component will be trained to all Facility Managers. All programs will be adjusted accordingly first in the Campus View Home for all individuals to ensure that this component is in place. QMRPs and Quality Assurance Manager will review all programs prior to implementation to ensure that frequency of data collection is present and complete. At least annually the QMRPs will review all programs prior to implementation to ensure that frequency of data collection is present and complete. Responsible: QMRP, Quality Assurance Manager Date of correction: May 25th, 2010	

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W 237	Continued From page 4 Individual #1's IPP included the following formal training objectives which did not specify the frequency at which data was to be collected: - Self Administration of Medication - Use a napkin to wipe food from his face. - Utilize his computer communication system. - Utilize his communication book. - Flush the toilet. - Use a washcloth during a bathing routine. - Use a towel . - Assist in the application of deodorant. - Pull his pants up. - Hold his arms still during the application of a shirt. - Wet the washcloth in the stream of water. When asked during an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the QMRP stated there were unwritten expectations regarding data collection, but the programs did not specify the frequency of data collection required for each program. 3. Individual #2's 2/20/10 IPP stated he was a 38 year old male whose diagnoses included mild mental retardation and schizophrenia. Individual #2's IPP included the following formal training objectives which did not specify the frequency at which data was to be collected: - Swallow his food before taking another bite. - Make his lunch. - Use a napkin. - Self Administration of Medication - Tie his shoes. - Initiate bathing routine.	W 237		

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W 237	Continued From page 5 - Make his bed. - Follow a written/picture routine. When asked during an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the QMRP stated there were unwritten expectations regarding data collection, but the programs did not specify the frequency of data collection required for each program. The facility failed to ensure Individual #1, #2, and #3's training programs included the frequency of data collection required.	W 237		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on policy and procedure review, record review, and staff interview, it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior for 1 of 1 individual (Individual #1) residing in the facility who used a power wheelchair for mobility. This resulted in interventions being used that were not included in the facility's policy. Findings include: 1. Individual #1's 11/21/09 IPP stated he was a 47 year old male whose diagnoses included severe mental retardation and cerebral palsy. He used a power wheelchair for independent mobility. Individual #1's record included a Program	W 276		

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W 276	Continued From page 6 Implementation Plan, dated 12/1/09, for maladaptive behaviors which included releasing his seatbelt on his wheelchair and flailing until falling to the ground, and attempting to run over staff and others with his power wheelchair. The plan stated staff were to take the following actions if Individual #1 became a risk to himself and others and less restrictive interventions had not been successful: - "If he does not calm, and begins to show increased physical aggression - disengage the power to the wheelchair and explain to [Individual #1] what you are doing." - "If [Individual #1] continues to flail around in attempt [sic] to get himself out of the wheelchair, staff needs to assist [Individual #1] to his room by pushing his wheelchair. Do not reengage the power at this point." - "If [Individual #1] unfastens his seatbelt and attempts to throw himself from his wheelchair onto the floor, a support staff needs to get the mat... Staff are to attempt to safely lower him to a floor mat that has been provided." However, the facility's Behavioral Intervention and Facility Practices policy, modified 2/19/08, did not include disabling an individual's power wheelchair, escorting an individual in a wheelchair to their room, or lowering an individual from their wheelchair to a mat as forms of behavioral intervention. When asked during an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the Administrator stated the behavioral interventions had not been included in the facility's policy.	W 276	W276: The Behavior Management Policy for the agency is updated to include the intervention in question. Review of the all client program files will be completed by QMRPs and Quality Assurance Manager to ensure that there are corresponding programmatic policies for all behavioral interventions that are used. An update/review to the Policy and Procedure Manual will take place to ensure that an established policy is in place prior to the implementation of a behavior intervention that requires restrictive policy to govern the practice. Provisions for the approval of the policy will be provided by Treatment Team and Human Rights Committee as presented. Responsible: QMRP, Quality Assurance Manager Date of correction: May 25th, 2010	

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W 276	Continued From page 7 The facility failed to ensure all approved behavioral interventions were included in the policy.	W 276		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review, review of the facility's policy and procedures, and staff interview, it was determined the facility failed to ensure the use of restraint was documented to present a clear understanding of the events prior to, during, and following its use for 1 of 1 individuals (Individual #1) reviewed for whom restraint was used. Failure to keep a comprehensive record of restraint usage would not allow the individual's IDT to make informed decisions and/or recommendations regarding the use of the restraint. The findings include: 1. Individual #1's 11/21/09 IPP stated he was a 47 year old male whose diagnoses included severe mental retardation and cerebral palsy. He used a power wheelchair for independent mobility. The facility's Behavioral Intervention and Facility Practices policy, modified 2/19/08, defined physical restraint as "any manual method or physical or mechanical device that the individual cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individuals body." Individual #1's record included a Program	W 303		

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W 303	Continued From page 8 Implementation Plan, dated 12/1/09, for maladaptive behaviors which included releasing his seatbelt on his wheelchair and flailing until falling to the ground, and attempting to run over staff and others with his power wheelchair. The plan stated if Individual #1 became a risk to himself and others staff were to disengage his power wheelchair, escort him to his room by pushing the wheelchair, and remove him from his wheelchair and lower him to a mat on the floor. The facility's incident reports from 10/1/09 - 3/22/10 were reviewed and documented the following behavioral interventions for Individual #1: - 10/2/09 at 9:15 a.m., staff disengaged his power wheelchair. - 10/2/09 at 3:00 p.m., staff disengaged his power wheelchair and lowered him to a mat. - 10/12/09 at 4:20 p.m., staff disengaged his power wheelchair, escorted him to his room, and lowered him to a mat. - 11/1/09 at 3:20 p.m., staff lowered him to a mat 6 times. - 11/5/09 at 9:15 a.m., staff lowered him to a mat. - 11/5/09 at 11:45 a.m., staff lowered him to the ground outside. - 11/22/09 at 5:50 p.m., staff disengaged his power wheelchair, escorted him to his room, and lowered him to a mat. - 11/24/09 at 8:30 a.m., staff disengaged his power wheelchair and escorted him to his room. - 11/30/09 at 7:15 a.m., staff escorted him to his room and lowered him to a mat. - 12/01/09 at 3:25 p.m., staff disengaged his power wheelchair, escorted him to his room, and lowered him to a mat. - 12/17/09 at 4:00 p.m., staff disengaged his	W 303	W303: The client's program in question has been updated to include a comprehensive record of restraint and staff training has occurred to ensure implementation. QMRPs, Facility Manager and Quality Assurance Manager will review facility documents to ensure that no individual has a program in place that warrants a record of restraint and will update the file to include a record of restraint. Treatment Team Review of programs that use restrictive measures will identify restraint methods that warrant a record of restraint. This information will also be added to our consent forms. At least annually IPP team will review current and proposed restrictive programs to ensure that all program approaches that require restraint methods have a record of restraint in place. Responsible: QMRPs, Facility Manager and Quality Assurance Manager Date of correction: April 10th, 2010	

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W 303	Continued From page 9 power wheelchair, escorted him to his room, and lowered him to a mat. - 1/5/10 at 5:20 p.m., staff disengaged his power wheelchair. - 1/24/10 at 5:40 p.m., staff disengaged his power wheelchair and escorted him to his room. - 1/29/10 at 9:30 a.m., staff lowered him to a mat. - 2/3/10 at 9:00 a.m., staff lowered him to a mat. - 3/3/10 at 2:50 p.m., staff lowered him to a mat. - 3/4/10 at 10:30 a.m., staff lowered him to a mat. - 3/4/10 at 3:30 p.m., staff disengaged his power wheelchair and escorted him to his room. - 3/20/10 at 1:10 p.m., staff disengaged his power wheelchair. - 3/21/10 at 2:55 p.m., staff escorted him to his room and lowered him to a mat. However, the documentation did not include sufficient record of restraint information to indicate how long Individual #1's wheelchair was disengaged, how long the escorts (staff moving Individual #1 to his room with his power wheelchair disengaged) took, or how long he remained on the mat. When asked during an interview on 3/25/10 from 11:30 a.m. - 1:00 p.m., the QMRP stated there was no additional documentation of restraint for Individual #1. The QMRP stated he realized the interventions used for Individual #1 were restrictive, but had not identified them as restraint. The facility failed to ensure accurate records of restraint were kept for Individual #1.	W 303		

Bureau of Facility Standards

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W153 and W157.	MM177	MM177 See W153 & W157	
MM182	16.03.11.075.09 (a)(iv) Resident placed in Restraints The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and This Rule is not met as evidenced by: Refer to W303.	MM182	MM182 See W303	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure toxic chemicals were kept in locked storage for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for physical	MM271		

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	13G070	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 1 harm to individuals who may have come in contact with the chemicals. The findings include: During an environmental assessment of the facility on 3/23/10 from 11:00 a.m. - 12:00 p.m., one partial gallon bucket of interior wall paint, one partial five gallon bucket of interior wall paint, three full gallons of chlorine bleach, five full bottles of toilet bowl cleaner, and one partial can of spray lubricant (WD-40) were observed on open shelving in the garage. Additionally, one partial tube of Super Glue was observed in an open box on the floor of the garage. In an interview on 3/23/10 at 12:00 p.m., the Home Manager stated the above referenced chemicals were supposed to be kept in a locked area. The facility failed to ensure toxic chemicals were stored in locked areas.	MM271	MM271 All chemicals have been labeled and locked up. This will be included on the revised building inspection monthly and signs will be posted at each home. Staff have been retrained to watch for any items that should be safeguarded in this manner. Responsibility: Random building inspections will be done by the Administrator, Quality Assurance Manager and QMRP to ensure the facility is complying with this issue. Completion: 4/21/2010	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the home was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:	MM380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 2 An environmental assessment was conducted on 3/23/10 from 11:00 a.m. - 12:00 p.m. During that time, the following was observed: - The caulking was missing around the baseboard behind and to the left of the toilet in the wheelchair accessible bathroom. - There was an approximate 1 inch hole in the wall behind the door in the wheelchair accessible bathroom. - The entry door to the bedroom shared by Individuals #1 and #4 was observed to have two holes, one approximately 1 inch round and one approximately 3 inches by 1 inch. - Individual #1 and #4's bedroom had a broken closet door with a 6 inch tear through the wood veneer. - Individual #1 and #4's bedroom had a 6 inch by 1/2 inch hole at the foot of the bed. - Individual #1 ans #4's bedroom had a dresser with a handle broken off of the bottom drawer. - The footboard of Individual #1's bed was cracked from top to bottom. - A section of the wall in Individual #1 and #4's bedroom had an approximate 8 inch by 12 inch section of wall without paint and 4 empty bolt holes were observed. The facility failed to ensure environmental repairs were maintained.	MM380	MM380 These items are currently on the building inspection. However, random building inspections will be done by the Administrator, Quality Assurance Manager and QMRP to ensure the facility is addressing repairs and maintenance issues in a timely manner. All repairs have either been completed or are slated to be completed by May 10, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G070	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS VIEW HOME	875 MONROE TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM520	Continued From page 3	MM520		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520	MM520 See W276	
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W237.	MM731	MM 731 See W237	